Optometric and Eyeglass Services

Provided by:

Ophthalmologists, Optometrists, Opticians and Eyeglass Providers

Medicaid , CHIP and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

April 2004

This publication supersedes all previous Optometric and Eyeglass Services provider handbooks. Published by the Montana Department of Public Health & Human Services, March 2003.

Updated July 2003, April 2004.

My Medicaid Provider ID Number:

My CHIP Provider ID Number:

MONTANA
Department of Public Health & Human Services

Table of Contents

Table of Contents **i.1**

Key Contacts **ii.1**

Introduction **1.1**
- Manual Organization 1.1
- Manual Maintenance 1.1
- Getting Questions Answered 1.1

Covered Services **2.1**
- General Coverage Principles 2.1
  - Services within scope of practice (ARM 37.85.401, 37.86.2001) 2.1
  - Dispensing services (ARM 37.86.2102) 2.1
  - Services for clients with limited Medicaid coverage 2.1
  - Services for children 2.2
  - Non-covered services (ARM 37.85.206, 37.85.207, 37.85.406) 2.2
  - Importance of fee schedules 2.2
  - Retroactive Eligibility 2.3
- Coverage of Specific Services 2.3
  - Contact lenses 2.3
  - Eye exams 2.4
  - Eyeglass services 2.4
  - Frame services 2.4
  - Lens add-ons 2.5
  - Lens styles and materials 2.6
  - Replacement lenses and frames 2.6
- Eyeglass Ordering Procedures 2.7
  - Tips for completing the Montana Medicaid Rx Form 2.7
  - Submitting the Medicaid Rx form 2.8
- Other Programs 2.8
  - Children's Health Insurance Plan (CHIP) 2.8
  - Mental Health Services Plan (MHSP) 2.8

Prior Authorization **3.1**
- What Are PASSPORT, Prior Authorization and the Restricted Card Programs? (ARM 37.86.5101 - 5120) 3.1
- Prior Authorization 3.2
- Other Programs 3.3

Coordination of Benefits **4.1**
- When Clients Have Other Coverage 4.1

Identifying Other Sources of Coverage 4.1
When a Client Has Medicare 4.1
Medicare Part A claims....4.2
Medicare Part B crossover claims 4.2
When Medicare pays or denies a service....4.2
When Medicaid does not respond to crossover claims....4.3
Submitting Medicare claims to Medicaid....4.3
When a Client Has TPL (ARM 37.85.407) 4.3
Exceptions to billing third party first....4.3
Requesting an exemption....4.4
When the third party pays or denies a service 4.4
When the third party does not respond 4.5
Other Programs 4.5

Billing Procedures....5.1
Claim Forms 5.1
Timely Filing Limits (ARM 37.85.406) 5.1
Tips to avoid timely filing denials 5.1
When To Bill Medicaid Clients (ARM 37.85.406) 5.2
Client Cost Sharing (ARM 37.85.204 and 37.85.402) 5.3
Usual and Customary Charge (ARM 37.85.406) 5.4
When Clients Have Other Insurance 5.4
Billing for Retroactively Eligible Clients 5.4
Place of Service 5.4
Multiple Visits on Same Date....5.4
Coding....5.5
Using the Medicaid Fee Schedule 5.6
Using Modifiers 5.7
Billing Tips for Specific Services....5.7
Bundled services 5.7
Contact lenses 5.7
Eye exams 5.7
Eyeglass services 5.8
Frame services 5.8
Lens add-ons 5.9
Replacement lenses and frames 5.9
Submitting Electronic Claims....5.9
Billing Electronically with Paper Attachments 5.10
Submitting Paper Claims 5.10
Claim Inquiries 5.10
The Most Common Billing Errors and How to Avoid Them 5.11
Other Programs 5.13

Completing a Claim Form 6.1
CMS-1500 Agreement....6.12
Avoiding Claim Errors....6.13
Other Programs 6.13

Remittance Advices and Adjustments 7.1
The Remittance Advice 7.1
Electronic RA 7.1
Paper RA 7.1
Credit balances 7.5
Rebilling and Adjustments 7.5
How long do I have to rebill or adjust a claim? 7.5
Rebilling Medicaid 7.5
Adjustments 7.6
Mass adjustments 7.9
Payment and The RA 7.9
Other Programs 7.10

How Payment Is Calculated 8.1
Overview 8.1
The RBRVS Fee Schedule 8.1
Fee calculation 8.1
Basis of relative values 8.1
Composition of relative values 8.2
Site of service differential 8.2
Conversion factor 8.2
Transition adjustor 8.2
Global periods 8.3
Professional and technical components 8.3
Other modifiers 8.3
Professional differentials 8.5
Charge cap 8.5
Payment by report 8.5
Bundled codes 8.5
Status codes 8.5
Payment For Eyeglasses 8.6
How Cost Sharing Is Calculated on Medicaid Claims 8.6
How Payment Is Calculated on TPL Claims 8.7
How Payment is Calculated on Medicare Crossover Claims 8.7
Other Department Programs 8.10

Appendix A: Forms A.1
Eyeglass Breakage and Loss Form A.2
Montana Medicaid Rx Form A.3
Montana CHIP Tx Form A.4
Montana Medicaid Claim Inquiry Form A.5
Montana Individual Adjustment Request Form A.6
Paperwork Attachment Cover Sheet A.7

Appendix B: Place of Service Codes B.1

Definitions and Acronyms.....C.1

Index.....D.1

Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated "In state" will not work outside Montana.

Provider Enrollment

For enrollment changes or questions:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena

Send written inquiries to:

Provider Enrollment Unit
P.O. Box 4936
Helena, MT 59604

Provider Relations

For questions about eligibility, payments, denials, general claims questions, or to request provider manuals or fee schedules:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Claims

Send paper claims to:

Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena

Send written inquiries to:

ACS Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

CHIP Eyeglass Services

CHIP Eyeglass Services
P.O. Box 202951
Helena, MT 59620-2951

(877) 543-7669 Toll free in state
(406) 444-6971 Phone
(406) 444-1899 Fax
chip@state.mt.us E-Mail

CHIP Optometric Services

Blue Cross and Blue Shield of Montana covers optometric services for CHIP clients. For more information or a billing manual, contact:

BlueCHIP
Blue Cross and Blue Shield of Montana
P.O. Box 4309
Helena, MT 59604

(800) 447-7828 Ext. 8647
(406) 447-8647

Optometric Program Officer

Send written inquiries to:

Optometric Program Officer
DPHHS
Medicaid Services Bureau
P.O. Box 202951
Helena, MT 59620

(406) 444-4540 Phone
(406) 444-1861 Fax

Restricted Client Authorization

For authorization for emergency services provided for restricted clients, contact the Surveillance/Utilization Review Section:

(406) 444-4167

All other services must be authorized by the client's designated provider.

Eyeglass Contractor

Walman Optical Company is contracted with DPHHS to provide eyeglasses to Medicaid and CHIP clients. Providers should call Walman to verify the client is eligible for eyeglasses. Dispensing providers may use any of the Montana Walman laboratories:

Keith Valley, Manager
454 Moore Lane, Suite 5
Billings, MT 59101
(406) 252-2143 Phone
(800) 759-5501 Toll free
(800) 642-4920 Fax

Gary Warneke, Manager
1245 South 3 West
Missoula, MT 59801
(406) 549-6429 Phone
(800) 877-3014 Toll free
(800) 551-3335 Fax

Dennis Kuntz, Manager
410 Central Avenue
Great Falls, MT 59401
(406) 761-2872 Phone
(800) 831-5889 Toll free
(406) 761-8194 Fax

Provider's Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see the *Introduction* chapter in the *General Information For Providers* manual.

Technical Services Center

Providers who have questions or changes regarding electronic funds transfer should call the number below and ask for the Direct Deposit Manager.

(406) 444-9500

Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

ACS EDI Gateway

For questions regarding electronic claims submissions:

(800) 987-6719 Phone
(850) 385-1705 Fax

ACS EDI Gateway Services
2324 Killearn Center Blvd.
Tallahassee, FL 32309

Prior Authorization

The following are some of the Department's prior authorization contractors. Providers are expected to refer to their specific provider manual for prior authorization instructions.

Surveillance/Utilization Review

For prior authorization for eye prosthesis, contact SURS at:

(406) 444-0190 Phone
(406) 444-0778 Fax

Send written inquiries to:
Surveillance/Utilization Review
2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953

Provider Relations

Contact Provider Relations to verify that the client is eligible for an eye exam or for PA for dispensing and fitting of contact lenses.

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena

Send written inquiries to:
Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

DPHHS

For prior authorization for transition lenses, tints other than Rose 1 and Rose 2, UV and scratch resistant coating, and polycarbonate lenses for Medicaid and CHIP clients:

For Medicaid clients:

(406) 444-4540 Phone
(406) 444-1861 Fax

Send written inquiries to:

Health Policy and Services Division
Medicaid Bureau - Optometric Program
P.O. Box 202951
Helena, MT 59620-2951

For CHIP clients:

(877) 543-7669 Toll free in state
(406) 444-6971 Phone
(406) 444-1899 Fax
chip@state.mt.us E-Mail

Send written inquiries to:

CHIP Eyeglass Services
P.O. Box 202951
Helena, MT 59620-2951

Key Web Sites

Web Address	Information Available
Virtual Human Services Pavilion (VHSP) vhsp.dphhs.state.mt.us	**Select *Human Services* for the following information:** • **Medicaid:** Medicaid Eligibility & Payment System (MEPS). Eligibility and claims history information. • **Senior and Long Term Care:** Provider search, home/housing options, healthy living, government programs, publications, protective/legal services, financial planning. • **DPHHS:** Latest news and events, Mental Health Services Plan information, program information, office locations, divisions, resources, legal information, and links to other state and federal websites. • **Health Policy and Services Division:** Children's Health Insurance Plan (CHIP), and Medicaid provider information such as manuals, newsletters, fee schedules, and enrollment information.
Provider Information Website www.mtmedicaid.org or www.dphhs.state.mt.us/hpsd/medicaid/medpi/medpi.htm	• Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • Newsletters • Key contacts • Links to other websites and more
CHIP Website www.chip.state.mt.us	• Information on the Children's Health Insurance Plan (CHIP)
Health Policy and Services Division (HPSD Home Page) www.dphhs.state.mt.us/hpsd	• **Medicaid:** See list under **Provider Information Website** above • **CHIP**: Information on the Children's Health Insurance Plan • **Public Health:** Disease prevention (immunizations), health and safety, health planning, and laboratory services • **Administration:** HPSD budgets, staff and program names and phone numbers, program statistics, and systems information. • **News:** Recent developments
ACS EDI Gateway www.acs-gcro.com/Medicaid_Account/Montana/montana.htm	ACS EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on: • Provider Services • EDI Support • Enrollment • Manuals • Software • Companion Guides
Washington Publishing Company www.wpc-edi.com	• EDI implementation guides • HIPAA implementation guides and other tools • EDI education

- Dispensing providers will evaluate existing frames to ensure lenses can be inserted.
- The eyeglass contractor will decide if the existing frame can be used for Medicaid covered lenses. If the existing frame cannot be used, the eyeglass contractor will inform the dispensing provider.
- If the existing frame breaks (after lenses are dispensed to the client), Medicaid will pay for a contract frame but not new lenses. The client can choose to pay privately for new lenses or find a contract frame that the lenses will fit. New lenses are not covered in this case.

Lens add-ons

Medicaid covers some "add-on" or special features for eyeglass lenses, and some are available on a private pay basis (see following table).

Lens Add-Ons

Lens Feature	Medicaid Covers for Children (Ages 20 & Under)	Medicaid Covers for Adults (Ages 21 and Older)	Client Cost Per Lens
Photochromic - plastic (i.e. Transition)	Yes - if medically necessary	No	$18.50
Photochromic - Glass (i.e. photogray, photobrown)	Yes - if medically necessary	No	$4.50
Progressive	No, but Medicaid will pay $21.00 and client must pay balance	No, but Medicaid will pay $21.00 and client must pay balance	VIP $30.50 XL $30.50 Percepta $34.00 Confort $35.50
Polycarbonate lenses (Single vision, Bifocal, or Trifocal lenses)	Yes - if client is monocular	Yes - if client is monocular	$4.00
Tints Rose 1 and Rose 2 (applicable to CR-39 and Polycarbonate lenses only)	Yes	Yes	No charge
Tints other than Rose 1 and Rose 2 (applicable to CR-39 and Polycarbonate lenses only)	Yes - if medically necessary	No	$1.25
UV and scratch-resistant coatings	Yes - if medically necessary	No	$1.50
Slab-off and fresnell prism	Yes - if medically necessary	Yes - if medically necessary	No charge

Any lens style, lens material, tint, coating lens enhancement (polished edge, etc.) not specifically noted above or within this manual will be billed to the dispensing provider at the contractor's normal and customary charges.

Lens styles and materials

All eyeglass lenses fabricated by the eyeglass contractor for Medicaid clients must be in the edged form, edged to shape and size for a specific frame and returned to the dispensing provider as "lenses only," or edged and mounted into a specific frame and returned to the dispensing provider as "complete Rx order." Orders for "uncut" lenses are not accepted.

Medicaid covers the following lens styles:

- Single vision
- Flattop segments 25, 28, 35
- Round 22
- Flattop trifocals 7 x 25, 7 x 28
- Executive style bifocals.

Medicaid covers the following lens materials (no high index):

- Glass
- CR-39
- Polycarbonate for monocular clients only. Medicaid clients who are not monocular can choose polycarbonate lenses and pay the difference as an add-on (see previous table of *Lens Add-Ons*).

Replacement lenses and frames

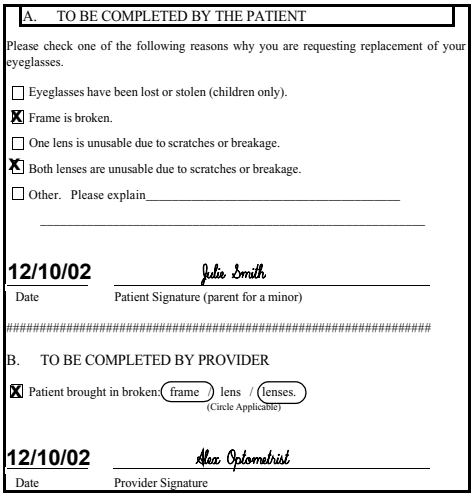
All frames provided by the Medicaid contractor carry a 24-month manufacturer warranty on replacement fronts and temples. Medicaid clients must bring their broken frames into the dispensing provider for the contractor to repair. No new frame style or color can replace the broken frame.

If an adult (ages 21 and older) loses his or her eyeglasses within the 24 months, Medicaid will not cover another pair. If an adult's lenses are broken or unusable, the client is eligible for replacement lenses (not frames) 12 months after the initial dispensing of contract eyeglasses.

If a child (ages 20 and under) loses or breaks the first pair of eyeglasses, and the damage is not covered by the warranty, Medicaid will replace one pair of eyeglasses within the 365 day period. Additional replacement requests must be reviewed by the Department Program Officer (see *Key Contacts*). Parents/guardians may purchase additional replacement eyeglasses at the Medicaid contract rate.

For lens and/or frame replacements, complete an *Eyeglass Breakage and Loss* form (see sample). Please circle *lens* if one lens is broken, and *lenses* if both lenses are broken. This form may be copied from *Appendix A Forms* or downloaded from the website.

Eyeglass Breakage and Loss Form



A. TO BE COMPLETED BY THE PATIENT

Please check one of the following reasons why you are requesting replacement of your eyeglasses.

☐ Eyeglasses have been lost or stolen (children only).
☒ Frame is broken.
☐ One lens is unusable due to scratches or breakage.
☒ Both lenses are unusable due to scratches or breakage.
☐ Other. Please explain_____

12/10/02 Julie Smith
Date Patient Signature (parent for a minor)

##########

B. TO BE COMPLETED BY PROVIDER

☒ Patient brought in broken: (frame) lens / (lenses.)
(Circle Applicable)

12/10/02 Alex Optometrist
Date Provider Signature

Eyeglass Ordering Procedures

Providers must complete the Montana Medicaid Rx Form to order eyeglasses from the Department's contractor (see *Appendix A Forms*).

Tips for completing the Montana Medicaid Rx Form

- The date of service for dispensing eyeglasses (measuring, verifying, and fitting) is the date the eyeglasses are ordered from the contractor.
- The date of service for eyeglass materials is the date the order is received by the eyeglass contractor.
- Encounters with the client on and after the date the glasses are dispensed are considered follow-up and are covered within the measuring, verifying, and fitting fee.
- Orders received by the eyeglass contractor after 3:00 p.m. will appear on the next business day and billed with this date of service.
- When the date of service is near the end of the month, please fax orders to the contractor. This will help ensure the client is eligible for eyeglasses since eligibility can change monthly. If you experience any difficulty faxing the contractor, please contact the contractor manager immediately (see *Key Contacts*).
- When completing the *Frame Information* section, remember the following:
  - Select *Supply* when ordering contract frame and lenses
  - Select *Lenses Only* when ordering lenses only
  - Check the *EPSDT* box when the Medicaid client is age 20 and under
  - *2nd PR S.V.* is used when ordering two pairs of single vision eyeglasses (one for distance and one for reading) when a Medicaid client cannot wear multi-focal eyeglasses. An ophthalmologist or optometrist must keep documentation of the client's inability to wear multi-focal eyeglasses.

When the date of service is near the end of the month, please fax orders to the eyeglasses contractor before 3:00 p.m. to ensure the client's eligibility, which can change monthly.

- *Rx Change* is used when a lens is ordered due to a prescription change which meets Medicaid guidelines (see *Eyeglass services* earlier in this chapter).

Submitting the Medicaid Rx form

- Attach a copy of the Faxback or MEPS printout verifying eligibility for the client (see the *Verifying Client Eligibility* section in the *General Information For Providers* manual) to the order form.
- If the service is "essential for employment," include a copy of the form with the order.
- Mail or fax the order form to the eyeglass contractor (see *Key Contacts*). Phone orders are not accepted. To ensure orders will be processed accurately and on time, all sections of the order form must be completed.
- Errors in the fabrication of eyeglasses made by the eyeglass contractor will be corrected by the contractor at no additional charge.
- If the dispensing provider makes a mistake on a prescription, the eyeglass contractor will correct the error (create a new lens with the correct prescription) and bill the dispensing provider at Medicaid contract rates.

Other Programs

This is how the information in this chapter applies to Department programs other than Medicaid.

Children's Health Insurance Plan (CHIP)

Eyeglass services are covered by CHIP, but optometric services are covered by the BlueCHIP Plan of Blue Cross and Blue Shield of Montana (see *Key Contacts*). Most of the eyeglass services information in this chapter applies to CHIP clients. The exceptions are as follows:

- Where the above text says "Medicaid covers," either CHIP or BlueCHIP covers for CHIP clients.
- CHIP clients do not receive retroactive eligibility.
- CHIP clients are 18 years of age and under.
- CHIP clients are eligible for eyeglasses every 365 days.
- CHIP clients are not eligible for replacement lenses or frames that are not covered under warranty.

Additional information regarding CHIP is available on the *Provider Information* website (see *Key Contacts*).

Mental Health Services Plan (MHSP)

Eye exams and eyeglasses are not covered under the Mental Health Services Plan (MHSP). See the *Mental Health Services Pla..* manual available on the *Provider Information* website.

Coordination of Benefits

When Clients Have Other Coverage

Medicaid clients often have coverage through Medicare, workers' compensation, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers must bill other carriers before billing Medicaid, but there are some exceptions (see *Exceptions to Billing Third Party First* later in this chapter). Medicare coverage is processed differently than other sources of coverage.

Identifying Other Sources of Coverage

The client's Medicaid ID card may list other payers such as Medicare or other third party payers (see *Client Eligibility and Responsibilities* in the *General Information For Providers* manual). If a client has Medicare, the Medicare ID number is listed on the card. If a client has other coverage (excluding Medicare), it will be shown under the "TPL" section of the ID card. Some examples of third party payers include:

- Private health insurance
- Employment-related health insurance
- Workers' compensation insurance*
- Health insurance from an absent parent
- Automobile insurance*
- Court judgments and settlements*
- Long term care insurance

*These third party payers (and others) may **not** be listed on the client's ID card.

Medicare claims are processed differently than other sources of coverage.

Providers must use the same procedures for locating third party sources for Medicaid clients as for their non-Medicaid clients. Providers cannot refuse service because of a third party payer or potential third party payer.

When a Client Has Medicare

Medicare claims are processed and paid differently than claims involving other payers. The other sources of coverage are referred to as "third party liability" (TPL), but Medicare is not.

Medicare Part A claims

Medicare Part A covers inpatient hospital care, skilled nursing care and other services. Medicare Part A services are covered in more detail in specific program manuals where the providers bill for Part A services.

Medicare Part B crossover claims

To avoid confusion and paperwork, submit Medicare Part B crossover claims to Medicaid only when necessary.

Medicare Part B covers physician care, eye exams, and other services. The Department has an agreement with Medicare Part B carriers for Montana (BlueCross BlueShield of Montana and the Durable Medical Equipment Regional Carrier [DMERC]). Under this agreement, the carriers provide the Department with a magnetic tape of CMS-1500 (formerly HCFA-1500) claims for clients who have both Medicare and Medicaid coverage. In order to have claims automatically cross over from Medicare to Medicaid, the provider must:

- Accept Medicare assignment (otherwise payment and the Explanation of Medicare Benefits (EOMB) go directly to the client and will not cross over).
- Submit their Medicare and Medicaid provider numbers to Provider Relations (see *Key Contacts*).

When submitting electronic claims with paper attachments, see the *Billing Electronically with Paper Attachments* section of the *Billing Procedures* chapter in this manual.

In these situations, providers need not submit Medicare Part B crossover claims to Medicaid. Medicare will process the claim, submit it to Medicaid, and send the provider an EOMB. Providers must check the EOMB for the statement indicating that the claim has been referred to Medicaid for further processing. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit (see *Billing Procedures*).

When Medicare pays or denies a service

- When Medicare pays an eye exam claim for a provider that is set up for automatic crossover, the claim should automatically cross over to Medicaid for processing, so the provider does not need to submit these claims to Medicaid.

  Providers that are not set up for automatic crossover should submit a claim to Medicaid after Medicare pays, and Medicaid will consider the claim for payment (see *Submitting Medicare claims to Medicaid* later in this chapter).

  If Medicare denies an eye exam claim, submit the claim to Medicaid (see *Submitting Medicare claims to Medicaid* later in this chapter).

All Part B Crossover claims submitted to Medicaid before Medicare's 45-day response time will be returned to the provider.

- Clients who have Medicare/QMB or Medicare/Medicaid coverage must choose whether to access their Medicare or Medicaid benefits for eyeglasses. If a client chooses to use Medicare, do not bill Medicaid, and any claims that cross over from Medicare will be denied.

- For clients who have QMB only coverage, the provider bills Medicare first for eyeglass claims, and if Medicare pays the claim, Medicaid will consider the claim for payment. If Medicare denies the claim, Medicaid will also deny the claim. For more information on QMB, see the *General Information For Providers* manual, *Client Eligibility* chapter.

When Medicaid does not respond to crossover claims

When Medicaid does not respond within 45 days of the provider receiving the Medicare EOMB, submit a claim, with a copy of the Medicare EOMB, to Medicaid for processing.

Remember to submit Medicare crossover claims to Medicaid only:

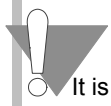
- When the "referral to Medicaid" statement is missing from the provider's EOMB.
- When the provider does not hear from Medicaid within 45 days of receiving the Medicare EOMB.

Submitting Medicare claims to Medicaid

When submitting a paper claim to Medicaid, attach the Medicare EOMB and use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must also include the Medicaid provider number and Medicaid client ID number.

When a Client Has TPL (ARM 37.85.407)

When a Medicaid client has additional medical coverage (other than Medicare), it is often referred to as third party liability or TPL. In most cases, providers must bill other insurance carriers before billing Medicaid.



It is the provider's responsibility to follow up on TPL claims and make sure they are billed correctly to Medicaid within the 12-month timely filing period.

Providers are required to notify their clients that any funds the client receives from third party payers (when the services were billed to Medicaid) must be turned over to the Department. The following words printed on the client's statement will fulfill this requirement: "When services are covered by Medicaid and another source, any payment the client receives from the other source must be turned over to Medicaid."

Exceptions to billing third party first

In a few cases, providers may bill Medicaid first.

- When a Medicaid client is also covered by Indian Health Service (IHS) or the Montana Crime Victim's Compensation Fund, providers must bill Medicaid before IHS or Crime Victim's. These are not considered third party liability.
- If the third party has only potential liability, such as automobile insurance, the provider may bill Medicaid first. Do not indicate the potential third party on the claim. Instead, notify the Department of the potential third party by sending the claim and a note to the ACS Third Party Liability Unit (see *Key Contacts*).

Requesting an exemption

Providers may request to bill Medicaid first under certain circumstances. In each of these cases, the claim and required information must be sent directly to the ACS Third Party Liability Unit (see *Key Contacts*).

- When a provider is unable to obtain a valid *assignment of benefits* (see *Definitions*), the provider must submit the claim with documentation that the provider attempted to obtain assignment and certification that the attempt was unsuccessful.
- When the child support enforcement division has required an absent parent to have insurance on a child, the claim can be submitted to Medicaid when the following requirements are met:
    1. The third party carrier has been billed, and 30 days or more have passed since the date of service.
    2. The claim is accompanied by a certification that the claim was billed to the third party carrier, and payment or denial has not been received.
- If another insurance has been billed, and 90 days have passed with no response, attach a note to the claim explaining that the insurance company has been billed (or attach a copy of the letter sent to the insurance company). Include the date the claim was submitted to the insurance company and certification that there has been no response.
- When the provider has billed the third party insurance and has received a non-specific denial (e.g., no client name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation directly to the TPL Unit (see *Key Contacts*) in order to avoid missing the timely filing deadline.

When the third party pays or denies a service

When a third party payer is involved (excluding Medicare) and the other payer:

- Pays the claim, indicate the amount paid in the "amount paid" field of the claim when submitting to Medicaid for processing. These claims may be submitted either electronically or on paper.
- Allows the claim, and the allowed amount went toward client's deductible, include the insurance Explanation of Benefits (EOB) when billing Medicaid. These claims must be submitted on paper.
- Denies the claim, include a copy of the denial (including the reason and the reason explanation) with the claim, and submit to Medicaid.
- Denies a line on the claim, bill the denied lines together on a separate claim and submit to Medicaid. Include the explanation of benefits (EOB) from the other payer as well as an explanation of the reason for denial (e.g., definition of denial codes).

Coding

Always refer to the long descriptions in coding books.

Standard use of medical coding conventions is required when billing Medicaid. Provider Relations or the Department cannot suggest specific codes to be used in billing for services. For coding assistance and resources, see the table of *Coding Resources* on the following page. The following suggestions may help reduce coding errors and unnecessary claim denials:

- Use current CPT-4, HCPCS Level II, and ICD-9-CM coding books.
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Follow CPT-4 guidelines on the difference between a new patient and an established patient.
- Bill for the appropriate level of service provided. For example, the CPT-4 coding book contains detailed descriptions and examples of what differentiates a level 1 established patient office visit (99211) from a level 4 office visit (99214).
- Services covered within "global periods" for certain CPT-4 procedures are not paid separately and must not be billed separately. Most surgical and some medical procedures include routine care before and after the procedure. Medicaid fee schedules show the global period for each CPT-4 service.
- Use the correct number of units on CMS-1500 claims. In general, Medicaid follows the definitions in the CPT-4 and HCPCS Level II coding manuals. Unless otherwise specified, one unit equals one visit or one procedure. For specific codes, however, one unit may be 15 minutes. Always check the long text of the code description.
- CPT codes that are billed based on the amount of time spent with the client must be billed with the code that is closest to the time spent. For example, a provider spends 60 minutes with the client. The code choices are 45 to 50 minutes or 76 to 80 minutes. The provider must bill the code for 45 to 50 minutes.

Coding Resources

Please note that the Department does not endorse the products of any particular publisher.

Resource	Description	Contact
ICD-9-CM	• ICD-9-CM diagnosis and procedure codes definitions • Updated each October.	Available through various publishers and bookstores American Optometric Association (800) 365-2219
CPT-4	• CPT-4 codes and definitions • Updated each January	American Medical Association (800) 621-8335 www.amapress.com or Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com or American Optometric Association (800) 365-2219 www.aoanet.org
HCPCS Level II	• HCPCS Level II codes and definitions • Updated each January and throughout the year	Available through various publishers and bookstores or from CMS at cms.hhs.gov/paymentsystems/hcpcs/2001rel.asp
CPT Assistant	A newsletter on CPT-4 coding issues	American Medical Association (800) 621-8335 www.amapress.com
Miscellaneous resources	Various newsletters and other coding resources.	Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
CCI Policy and Edits Manual	This manual contains Correct Coding Initiative (CCI) policy and edits, which are pairs of CPT-4 or HCPCS Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same client on the same date of service.	National Technical Information Service (800) 363-2068 (703) 605-6060 www.ntis.gov/product/correct-coding.htm

Using the Medicaid Fee Schedule

When billing Medicaid, it is important to use the Department's fee schedule for your provider type in conjunction with the detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. In addition to covered services and payment rates, fee schedules often contain helpful information such as global periods, if multiple surgery guidelines apply, if the procedure can be done bilaterally, if an assistant, co-surgeon, or team is allowed for the procedure, if the code is separately billable, if prior authorization is required, and more. Depart-

ment fee schedules are updated each January and July. Current fee schedules are available on the *Provider Information* website (see *Key Contacts*). For disk or hardcopy, contact Provider Relations (see *Key Contacts*).

Using Modifiers

- Review the guidelines for using modifiers in the most current CPT-4, HCPCS Level II, or other helpful resources.
- Always read the complete description for each modifier; some modifiers are described in the CPT-4 manual while others are in the HCPCS Level II book.
- The Medicaid claims processing system recognizes only two pricing modifiers and one informational modifier per claim line. Providers are asked to place any modifiers that affect pricing in the first two modifier fields.
- When billing with modifier 50 for bilateral services, put all information on one line with one unit. You do not need to use modifiers for left and right, and do not bill on separate lines. For example, a bilateral close tear duct opening procedure would be billed like this:
- Check the fee schedule to see if Medicaid allows the use of the following modifiers for a particular code: bilateral (50), multiple procedures (51), co-surgery (62), assistant at surgery (80, 81, 82, AS), and team surgery (66).

24. A						B	C	D	E	F	G	H	I	J	K
DATE(S) OF SERVICE From			To			Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
MM	DD YY	MM	DD YY												
1 02	23 03	02	23 03			11		68761 | 50	1	250 00	1					

Billing Tips for Specific Services

Bundled services

Certain services with CPT-4 or HCPCS codes (eg., tear duct plugs) are covered by Medicaid but have a fee of zero. This means that the service is typically "bundled" with an office visit or other service. Since the bundled service is covered by Medicaid, providers may not bill the client separately for it.

Contact lenses

When billing Medicaid for contact lenses, include the prior authorization number on the claim (field 23 of the CMS-1500 form).

Eye exams

- A client may be eligible for an eye exam before the specified time limit expires if he or she meets the criteria described in the *Covered Services* chapter, *Eye exams* section of this manual. In this case, enter the reason for the exam on the claim (box 19 of the CMS-1500 claim form).
- Medicare does not cover eye refraction (92015) but instructs providers to report this service as a separate line item from the other service(s) per-

formed. Medicaid covers this procedure, so providers can bill for the eye exam and the refraction.

- Children (age 20 and under for Medicaid or 18 and under for CHIP) may receive an additional exam before the 365-day limit has passed if they have had at least a one line acuity change resultin gin prescribing replacement lenses that meet the criteria in the *Eyeglass services* section of the *Covered Services* chapter in this manual. In this case, providers may bill Medicaid for the exam using EPSDT indicator 1 on the claim (field 24h on the CMS-2500 form). See the *Completing a Claim* chapter in this manual.

Eyeglass services

- Adult clients (ages 21 and older) may receive new lenses before the 730-day limit has passed if they meet the criteria described the *Eyeglass services* section of the *Covered Services* chapter in this manual. In this case, providers may bill Medicaid for a dispensing fee for new lens(es) using modifier Z8 with the dispensing fee procedure code.
- Children (age 20 and under for Medicaid or 18 and under for CHIP) may receive new lenses before the 365-day limit has passed if they meet the criteria in the *Eyeglass services* section of the *Covered Services* chapter in this manual. In this case, providers may bill Medicaid for a dispensing fee for new lens(es) using EPSDT indicator 1 on the claim (field 24H of the CMS-1500 claim form).
- If the adult Medicaid client (age 21 and over) is not eligible for lens(es) and/or frame within the 730-day period *(*see *Covered Services* chapter, *Eyeglass services*) the dispensing provider may not bill Medicaid for a dispensing fee. If the client chooses to purchase eyeglasses privately, the provider may bill the Medicaid client for dispensing services and eyeglass materials.
- The eyeglass contractor will bill Medicaid for the laboratory and material costs for lenses and frames.
- Please bill CHIP for eyeglass services and BlueCHIP for optometric services.

Frame services

- When the Medicaid client uses an existing frame, the dispensing provider bills Medicaid for dispensing services, lenses only.
- Providers may not charge a dispensing fee for minor frame repairs that they provide themselves.
- If a client that is covered by Medicare and Medicaid chooses a frame outside the Medicaid contract, the provider cannot bill Medicaid for the dispensing fee. All charges must be billed to Medicare and the client.

Lens add-ons

The eyeglass contractor bills the dispensing provider their usual and customary charge for any lens style, lens material, tint, coating lens enhancement (polished edge, etc.) not covered by Medicaid (see *Covered Services*, *Lens add-ons*). It is the dispensing provider's responsibility to bill the Medicaid client for these items. Do not bill Medicaid.

For example, FT7x35 Trifocal is billed to the dispensing provider at the contractor's usual and customary price, not at a price which would reflect the difference between the contract price for 7x28, and the usual and customary 7x35 price.

For FT 28 CR-39 with polished edges, only the polished edge price is billed to the dispensing provider at the contractor's usual and customary charge.

Replacement lenses and frames

If a client has selected to use an existing frame, and the existing frame breaks after lenses were dispensed to the client, Medicaid will not cover new lenses. The Medicaid client may privately pay for new lenses or select a contract frame that the existing lenses will fit into. If a contract frame is selected, the dispensing provider may bill Medicaid for dispensing services, frame only.

Submitting Electronic Claims

Professional and institutional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- ***ACS field software WINASAP 2003.*** ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 (electronic RA) transaction back from the Department. The software can be downloaded directly from the ACS EDI Gateway website. For more information on WINASAP 2003, visit the ACS EDI Gateway website, or call the number listed in the *Key Contacts* section of this manual.
- ***ACS clearinghouse.*** Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway. For more information on using the ACS clearinghouse, contact ACS EDI Gateway (see *Key Contacts*).

- ***Clearinghouse.*** Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to the ACS clearinghouse. EDIFECS certification is completed through ACS EDI Gateway.

Providers should be familiar with the *Implementation Guides* that describe federal rules and regulations and provide instructions on preparing electronic transactions. These guides are available from the Washington Publishing Company (see *Key Contacts*). *Companion Guides* are used in conjunction with *Implementation Guides* and provide Montana-specific information for sending and receiving electronic transactions. They are available on the ACS EDI Gateway website (see *Key Contacts*).

Billing Electronically with Paper Attachments

When submitting claims that require additional supporting documentation, the *Attachment Control Number* field must be populated with an identifier. Identifier formats can be designed by software vendors or clearinghouses, but the preferred method is the provider's Medicaid ID number followed by the client's ID number and the date of service, each separated by a dash:

9999999	-	**888888888**	-	**11182003**
Medicaid Provider ID		Client ID Number		Date of Service (mmddyyyy)

The supporting documentation must be submitted with a paperwork attachment coversheet (located on the Provider Information website and in *Appendix A: Forms*). The number in the paper *Attachment Control Number* field must match the number on the cover sheet. For more information on attachment control numbers and submitting electronic claims, see the *Companion Guides* located on the ACS EDI website (see *Key Contacts*).

Submitting Paper Claims

For instructions on completing a paper claim, see the *Completing a Claim* chapter in this manual. Unless otherwise stated, all paper claims must be mailed to:

Claims Processing
P.O. Box 8000
Helena, MT 59604

Claim Inquiries

The *Provider Information* website contains billing instructions, manuals, notices, fee schedules, answers to commonly-asked questions and much more (see *Key Contacts*). The information available may be downloaded and shared with others

in your office. If you cannot find answers to your questions on the website, or if you have questions on a specific claim, contact Provider Relations (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix A*. Complete the top portion of the form with the provider's name and address.

Provider Relations will respond to the inquiry within 7 to 10 days. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double check each claim to confirm the following items are included and accurate.

Common Billing Errors

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a CMS-1500 claim form (or electronic Professional claim).
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the client: • View the client's ID card at each visit. Medicaid eligibility may change monthly. • Verify client eligibility by using one of the methods described in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual.

Common Billing Errors (continued)

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Duplicate claim	• Please check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim (see *Remittance Advices and Adjustments* in this manual). • Please allow 45 days for the Medicare/Medicaid Part B crossover claim to appear on the RA before submitting the claim directly to Medicaid.
Medicare Part B crossover claims submitted before Medicare's 45-day crossover limit	Claims that cross over between Medicare Part B and Medicaid should not be billed on paper to Medicaid until 45 days after the Medicare Part B paid date. These claims will be returned to the provider.
Prior authorization number is missing	• Prior authorization (PA) is required for certain services, and the PA number must be on the claim (see the *PASSPORT and Prior Authorization* chapter in this manual). • Mental Health Services Plan (MHSP) claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization. See the *Mental Health Services Plan* manual.
TPL on file and no credit amount on claim	• If the client has any other insurance (or Medicare), bill the other carrier before Medicaid. See *Coordination of Benefits* in this manual. • If the client's TPL coverage has changed, providers must notify the TPL unit (see *Key Contacts*) before submitting a claim.
Claim past 365-day filing limit	• The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. • To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in *Key Contacts*.
Missing Medicare EOMB	All Medicare crossover claims on CMS-1500 forms must have an Explanation of Medicare Benefits (EOMB) attached, and be billed to Medicaid on paper.
Provider is not eligible during dates of services, or provider number terminated	• Out-of-state providers must update enrollment early to avoid denials. If enrollment has lapsed, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.

Common Billing Errors (continued)	
Reasons for Return or Denial	**How to Prevent Returned or Denied Claims**
Type of service/procedure is not allowed for provider type	• Provider is not allowed to perform the service, or type of service is invalid. • Verify the procedure code is correct using current HCPCS and CPT-4 billing manual. • Check the Medicaid fee schedule to verify the procedure code is valid for your provider type.

Other Programs

The billing procedures for eyeglass services apply to the Children's Health Insurance Plan (CHIP). The billing procedures for eye exams do not apply to CHIP because optometric services are covered by the BlueCHIP Plan of Blue Cross and Blue Shield of Montana (see *Key Contacts*).

These billing procedures do not apply to the Mental Health Services Plan (MHSP). The MHSP manual is available on the *Provider Information* website (see *Key Contacts*).

MONTANA
Department of Public Health & Human Services

Completing a Claim Form

The services described in this manual are billed either electronically on a Professional claim or on a paper CMS-1500 claim form. Claims submitted with all of the necessary information are referred to as "clean" and are usually paid in a timely manner (see the *Billing Procedure*s chapter in this manual).

Claims are completed differently for the different types of coverage a client has. This chapter includes instructions and a sample claim for each of the following scenarios:

- Client has Medicaid coverage only
- Client has Medicaid and Medicare coverage
- Client has Medicaid and third party liability coverage
- Client has Medicaid, Medicare, and third party liability coverage
- Client has Medicaid, Medicare, and Medicare supplement coverage

When completing a claim, remember the following:

- Required fields are indicated by "*".
- Fields that are required if the information is applicable to the situation or client are indicated by "**".
- Field 24h, *EPSDT/family planning*, is used to override cost sharing, limits, or PASSPORT authorization requirements for certain clients or services. The following are accepted codes:

EPSDT/Family Planning Overrides

Code	Client/Service	Purpose
1	EPSDT	Overrides benefit limits for client under age 21
2	Family planning	Overrides the Medicaid cost sharing and PASSPORT authorization on the line
3	EPSDT and family planning	Overrides Medicaid cost sharing and PASSPORT authorization for persons under the age of 21
4	Pregnancy (any service provided to a pregnant woman)	Overrides Medicaid cost sharing on the claim
6	Nursing facility client	Overrides the Medicare edit for oxygen services on the **line**

- Unless otherwise stated, all paper claims must be mailed to the following address:

  Claims Processing Unit
  P.O. Box 8000
  Helena, MT 59604

Client Has Medicaid Coverage Only

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a	Insured's ID number	Leave this field blank for Medicaid only claims.
2*	Patient's name	Enter the client's name as it appears on the Medicaid ID card.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
5	Patient's address	Client's address.
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on their ID card.
11d*	Is there another health benefit plan?	Enter "No". If "Yes", follow claim instructions for appropriate coverage later in this chapter.
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format. This field is optional for Medicaid only claims.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format. This field is optional for Medicaid only claims.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization. This field is optional for Medicaid only claims.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix B*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter the appropriate CPT-4/HCPCS modifier. Medicaid allows up to three modifiers per procedure code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your usual and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures*, *Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4, 5 or 6 (see complete description in the *EPSDT/Family Planning Overrides* table earlier in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave blank or enter $0.00. Do not report any client copay or Medicaid payment amounts on this form.
30	Balance due	Enter the balance due as recorded in field 28.
31*	Signature and date	This field must contain an authorized signature and date, which is either hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

MONTANA
Department of Public Health & Human Services

Remittance Advices and Adjustments

The Remittance Advice

The Remittance Advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered. The RA provides details of all transactions that have occurred during the previous RA cycle. Providers may select a one or two week payment cycle (see *Payment and the RA* in this chapter). Each line of the RA represents all or part of a claim, and explains whether the claim or service has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the RA also shows the reason.

Electronic RAs are available for only six weeks on MEPS.

Electronic RA

Providers may receive the RA electronically as an ANSI ASC X12N 835 transaction, or through the Internet on the Montana Eligibility and Payment System (MEPS). For more information on X12N 835 transactions, see the Companion Guides available on the ACS EDI Gateway website and the Implementation Guides on the Washington Publishing Company website (see *Key Contacts*).

MEPS is available through the Virtual Human Services Pavilion (see *Key Contacts*). In order to access MEPS, you must complete an *Access Request Form;* see *Payment and the RA* within this chapter). After this form has been processed, you will receive a password. Entry into the system requires a valid provider or group number and password. Each provider or group number requires a unique password, so providers must complete a separate request form for each provider or group.

If a claim was denied, please read the reason and remark code description before taking any action on the claim.

RAs are available from MEPS in PDF and a flat file format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the "SOR Download" page. The file layout for flat files is also available on the SOR download page. Due to space limitations, each RA is only available for six weeks. For more information on MEPS, see *Payment and the RA* later in this chapter.

Paper RA

The paper RA is divided into the following sections: RA notice, paid claims, denied claims, pending claims, credit balance claims, gross adjustments, and reason and remark codes and descriptions. See the following sample paper RA and the *Keys to the Paper RA* table.

The pending claims section of the RA is informational only. Please do not take any action on claims displayed here.

Sections of the Paper RA

Section	Description
RA notice	The RA Notice is on the first page of the remittance advice. This section contains important messages about rate changes, revised billing procedures, and many other items that may affect providers and claims.
Paid claims	This section shows claims paid during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit requiring the provider to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted (see *Adjustments* later in this chapter).
Denied claims	This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark column (Field 16). The reason and remark code description explains why the claim was denied and is located at the end of the RA. See *The Most Common Billing Errors and How to Avoid Them* in the *Billing Procedures* chapter.
Pending claims	All claims that have not reached final disposition will appear in this area of the paper RA (pended claims are not available on X12N 835 transactions). The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/Remark Code column (Field 16). The reason and remark code description located at the end of the RA will explain why the claim is suspended. This section is informational only. Please do not take any action on claims displayed here. Processing will continue until each claim is paid or denied. Claims shown as pending with reason code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for client eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.
Credit balance claims	Credit balance claims are shown here until the credit has been satisfied.
Gross adjustments	Any gross adjustments performed during the previous cycle are shown here.
Reason and remark code description	This section lists the reason and remark codes that appear throughout the RA with a brief description of each.

Sample Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
HELENA, MT 59604

MEDICAID REMITTANCE ADVICE

(1)

JOHN R. SMITH MD
2100 NORTH MAIN STREET
WESTERN CITY MT 59988

(2) PROVIDER# 0001234567 (3) REMIT ADVICE #123456 (4) WARRANT # 654321 (5) DATE:02/15/03 PAGE 2 (6)

RECIP ID (7)	NAME (8)	SERVICE DATES FROM TO (10)	UNIT OF SVC (11)	PROCEDURE REVENUE NDC (12)	TOTAL CHARGES (13)	ALLOWED (14)	CO-PAY (15)	REASON/ REMARK CODES (16)
PAID CLAIMS - MISCELLANEOUS CLAIMS								
123456789	DOE, JOHN EDWARD	013103 013103	1	99212	35.00	28.90	Y	
(9) ICN	00204011250000700							
		LESS MEDICARE PAID*******				21.95		
		LESS COPAY DEDUCTION**				2.00 (17)		
		CLAIM TOTAL*******			35.00	4.95		
DENIED CLAIMS - MISCELLANEOUS CLAIMS								
123456789	DOE, JOHN EDWARD	020303 020303	1	99213	45.00	0.00	N	
ICN	00204011250000800	ADDITIONAL EOB: 082 (16)						
		020403 020403	1	99214	60.00	0.00 (17)	N	
		CLAIM TOTAL*******			105.00			31MA61
PENDING CLAIMS - MISCELLANEOUS CLAIMS								
123456789	DOE, JOHN EDWARD	020503 020503	1	99213	45.00	0.00 (17)	N	133
ICN	00204011250000900	020603 020603	1	99214	60.00	0.00	N	133
		CLAIM TOTAL*******			105.00			

**********THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE**********

31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.

133 THE DISPOSITION OF THIS CLAIM/SERVICE IS PENDING FURTHER REVIEW.

MA61 DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.

Key Fields on the Remittance Advice

Field	Description
1. Provider name and address	Provider's business name and address as recorded with the Department
2. Provider number	The 7-digit number assigned to the provider by Medicaid
3. Remittance advice number	The remittance advice number
4. Warrant number	Not used
5. Date	The date the RA was issued
6. Page Number	The page number of the RA
7. Recipient ID	The client's Medicaid ID number
8. Name	The client's name
9. Internal control number (ICN)	Each claim is assigned a unique 17-digit number (ICN). Use this number when you have any questions concerning your claim. The claim number represents the following information: 0 00111 00 123 000123 A B C D E A = Claim medium 0 = Paper claim 2 = Electronic claim 3 = Encounter claim 4 = System generated claim (mass adjustment, nursing home turn-around document, or point-of-sale (POS) pharmacy claim) B = Julian date (e.g. April 20, 2000 was the 111th day of 2000) C = Microfilm number 00 = Electronic claim 11 = Paper claim D = Batch number E = Claim number If the first number is: 0 = Regular claim 1 = Negative side adjustment claim (Medicaid recovers payment) 2 = Positive side adjustment claim (Medicaid reprocesses)
10. Service dates	Date(s) services were provided. If service(s) were performed in a single day, the same date will appear in both columns
11. Unit of service	The units of service rendered under this procedure, NDC, or revenue code.
12. Procedure/revenue/NDC	The procedure code (CPT, HCPCS, or local), National Drug Code (NDC), or revenue code will appear in this column. If a modifier was used, it will also appear in this column.
13. Total charges	The amount a provider billed for this service.
14. Allowed	The Medicaid allowed amount.
15. Copay	A "Y" indicates cost sharing was deducted from the allowed amount, and an "N" indicates cost sharing was not deducted.
16. Reason/Remark Codes	A code which explains why the specific service was denied or pended. Descriptions of these codes are listed at the end of the RA.
17. Deductions, billed amount, and paid amount	Any deductions, such as cost sharing or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement.

Credit balances

Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the RA until the credit has been satisfied.

The credit balance section is informational only. Do not post from credit balance statements.

Credit balances can be resolved in two ways:

1. By "working off" the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
2. By sending a check payable to DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Please attach a note stating that the check is to pay off a credit balance and include your provider number. Send the check to the attention of the *Provider Relations Field Representative* at the Provider Relations address in *Key Contacts*.

Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

How long do I have to rebill or adjust a claim?

Medicaid does not accept any claim for resubmission or adjustment after 12 months from the date of service (see *Timely Filing Limits* in *Billing Procedures* chapter).

- Providers may resubmit or adjust any initial claim within the timely filing limits described in the *Billing Procedures* chapter of this manual.
- These time periods do not apply to overpayments that the provider must refund to the Department. After the 12 month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check or requesting Provider Relations to complete a gross adjustment.

Rebilling Medicaid

Rebilling is when a provider submits a claim (or claim line) to Medicaid that was previously submitted for payment but was either returned or denied. Claims are often returned to the provider before processing because key information such as Medicaid provider number or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the *Billing Procedures* and *Completing a Claim* chapters.

When to rebill Medicaid

Rebill denied claims only after appropriate corrections have been made.

- ***Claim Denied.*** Providers can rebill Medicaid when a claim is denied in full, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the Explanation of Benefits (EOB) code, make the appropriate corrections, and resubmit the corrected claim on a CMS-1500 form (not the adjustment form).

- ***Line Denied.*** When an individual line is denied on a multiple-line claim, correct any errors and rebill Medicaid. Either submit the denied service on a new CMS-1500 form, or cross out paid lines and resubmit the form. Do not use an adjustment form.
- ***Claim Returned.*** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit your claim.

How to rebill

- Check any EOB code listed and make your corrections on a copy of the claim, or produce a new claim with the correct information.
- When making corrections on a copy of the claim, remember to cross out or omit all lines that have already been paid. The claim must be neat and legible for processing.
- Enter any insurance (TPL) information on the corrected claim, or attach insurance denial information to the corrected claim, and send it to Claims Processing (see *Key Contacts*).

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations (see *Key Contacts*) or submit a claim inquiry for review (see *Billing Procedures, Claim Inquiry*). Once an incorrect payment has been verified, the provider may submit an *Individual Adjustment Request* form (in *Appendix A*) to Provider Relations. If incorrect payment was the result of an ACS keying error, contact Provider Relations.

Adjustments can only be made to paid claims.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same RA as the credit transaction. The replacement transaction will have nearly the same ICN number as the credit transaction, except the 12th digit will be a 2, indicating an adjustment. See *Key Fields on the Remittance Advice* earlier in this chapter. Adjustments are processed in the same time frame as claims.

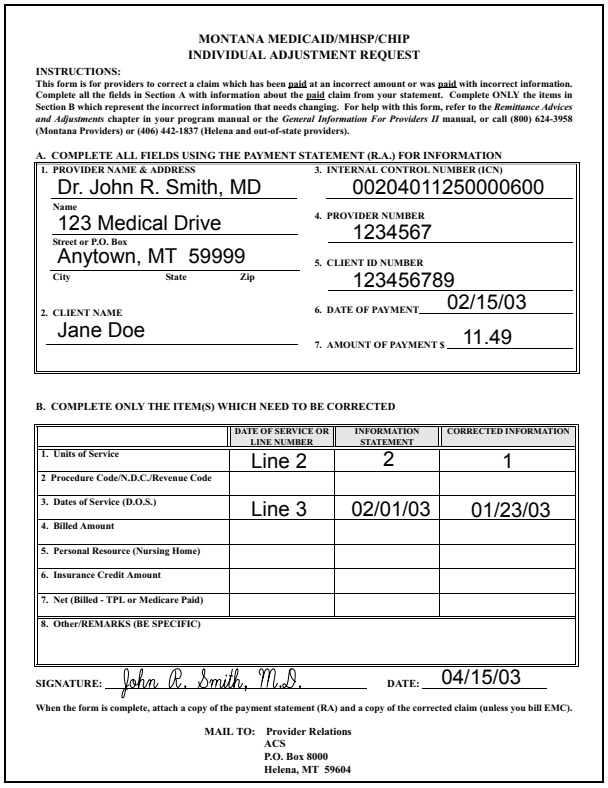
When to request an adjustment

- Request an adjustment when a claim was overpaid or underpaid.
- Request an adjustment when a claim was paid but the information on the claim was incorrect (such as client ID, provider number, date of service, procedure code, diagnoses, units, etc.).

How to request an adjustment

To request an adjustment, use the *Montana Medicaid Individual Adjustment Request* form in *Appendix A*. The requirements for adjusting a claim are as follows:

- Claims Processing must receive individual claim adjustment requests within 12 months from the date of service (see *Timely Filing Limits* in the *Billing Procedures* chapter). After this time, *gross adjustments* are required (see *Definitions*).
- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the *Remarks* section of the adjustment form.



MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:
This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS
Dr. John R. Smith, MD
Name
123 Medical Drive
Street or P.O. Box
Anytown, MT 59999
City State Zip

2. CLIENT NAME
Jane Doe

3. INTERNAL CONTROL NUMBER (ICN)
00204011250000600

4. PROVIDER NUMBER
1234567

5. CLIENT ID NUMBER
123456789

6. DATE OF PAYMENT 02/15/03

7. AMOUNT OF PAYMENT $ 11.49

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service	Line 2	2	1
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)	Line 3	02/01/03	01/23/03
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: John R. Smith, M.D. DATE: 04/15/03

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: Provider Relations
ACS
P.O. Box 8000
Helena, MT 59604

Sample Adjustment Request

Completing an Adjustment Request Form

1. Copy the *Montana Medicaid Individual Adjustment Request* form from *Appendix A*. You may also order forms from Provider Relations or download them from the *Provider Information* website (see *Key Contacts*). Complete Section A first with provider and client information and the claim's ICN number (see following table and sample RA).
2. Complete Section B with information about the claim. Remember to fill in only the items that need to be corrected (see following table):
   - Enter the date of service or the line number in the *Date of Service or Line Number* column.
   - Enter the information from the claim that was incorrect in the *Information on Statement* column.
   - Enter the correct information in the column labeled *Corrected Information*.

Completing an Individual Adjustment Request Form

Field	Description
Section A	
1. Provider name and address	Provider's name and address (and mailing address if different).
2. Client name	The client's name is here.
3.* Internal control number (ICN)	There can be only one ICN per adjustment request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent adjusted claim.
4.* Provider number	The provider's Medicaid ID number.
5.* Client Medicaid number	Client's Medicaid ID number.
6. Date of payment	Date claim was paid is found on remittance advice field #5 (see the sample RA earlier in this chapter).
7. Amount of payment	The amount of payment from the remittance advice field #17 (see the sample RA earlier in this chapter.).
Section B	
1. Units of service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure code/ NDC/ Revenue code	If the procedure code, NDC, or revenue code is incorrect, complete this line.
3. Dates of service (D.O.S)	If the date(s) of service is incorrect, complete this line.
4. Billed amount	If the billed amount is incorrect, complete this line.
5. Personal resource (Nursing facility)	If the client's personal resource amount is incorrect, complete this line.
6. Insurance credit amount	If the client's insurance credit amount is incorrect, complete this line.
7. Net (Billed – TPL or Medicare paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount third party liability or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

* Indicates a required field

3. Attach copies of the RA and a corrected claim if necessary.
   - If the original claim was billed electronically, a copy of the RA will suffice.
   - If the RA is electronic, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Claims Processing (see *Key Contacts*).

- If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.
- If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount through a credit balance or a check from the provider (see *Credit balances* earlier in this chapter).
- Any questions regarding claims or adjustments can be directed to Provider Relations (see *Key Contacts*).

Mass adjustments

Mass adjustments are done when it is necessary to reprocess multiple claims. They generally occur when:

- Medicaid has a change of policy or fees that is retroactive. In this case federal laws require claims affected by the changes to be mass adjusted.
- A system error that affected claims processing is identified.

Providers are informed of mass adjustments by a Provider Notice or on the first page of the remittance advice (RA Notice section). Mass adjustment claims shown on the RA have an ICN that begins with a "4" (see *Key Fields on the Remittance Advice* earlier in this chapter).

Payment and The RA

Providers may receive their Medicaid payment and remittance advice either weekly or biweekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who wish to receive weekly payment must request both EFT and electronic RAs and specifically request weekly payment. For biweekly payment, providers can choose any combination of paper/electronic payment method and RA.

With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

To participate in EFT, providers must complete a *Direct Deposit Sign-Up Form* (Standard Form 1199A). One form must be completed for each provider number. See the following table, *Required Forms for EFT and/or Electronic RA*.

Weekly payments are available only to providers who receive both EFT **and** electronic RAs.

Once electronic transfer testing shows payment to the provider's account, all Medicaid payments will be made through EFT. For questions or changes regarding EFT, contact the Technical Services Center and ask for the Medicaid Direct Deposit Manager (see *Key Contacts*).

Required Forms For EFT and/or Electronic RA

All three forms are required for a provider to receive weekly payment

Form	Purpose	Where to Get	Where to Send
Electronic Remittance Advice and Payment Cycle Enrollment Form	Allows provider to receive electronic remittance advices on MEPS (must also include MEPS Access Request form)	• Provider Information website • Provider Relations (see *Key Contacts*)	Provider Relations (see *Key Contacts*)
Direct Deposit Sign-up Form Standard Form 1199A	Allows the Department to automatically deposit Medicaid payment into provider's bank account	• Provider Information website • Provider's bank • Division of Payment Management web site (see *Key Contacts*)	Provider Relations (see *Key Contacts*)
MEPS Access Request Form	Allows provider to receive a password to access their RA on MEPS	• Provider Information website • Virtual Human Services Pavilion (see *Key Contacts*) • Direct Deposit Manager of the DPHHS Technical Services Center (see *Key Contacts)*	DPHHS address on the form

Other Programs

The information in this chapter applies to the Children's Health Insurance Plan (CHIP) eyeglasses only. Optometric services are covered under the BlueCHIP plan of BlueCross BlueShield of Montana.

Appendix A: Forms

- ***Eyeglass Breakage and Loss Form***
- ***Montana Medicaid Rx Form***
- ***Montana CHIP Rx Form***
- ***Montana Medicaid Claim Inquiry Form***
- ***Montana Individual Adjustment Request Form***
- ***Paperwork Attachment Cover Sheet***

Eyeglass Breakage and Loss Form

A. TO BE COMPLETED BY THE PATIENT

Please check one of the following reasons why you are requesting replacement of your eyeglasses.

- ☐ Eyeglasses have been lost or stolen (children only).
- ☐ Frame is broken.
- ☐ One lens is unusable due to scratches or breakage.
- ☐ Both lenses are unusable due to scratches or breakage.
- ☐ Other. Please explain_____

_____

_____ _____

Date Patient Signature (parent for a minor)

##########

B. TO BE COMPLETED BY PROVIDER

☐ Patient brought in broken: frame / lens / lenses.
(Circle Applicable)

_____ _____

Date Provider Signature

MONTANA
Department of Public Health & Human Services

Paperwork Attachment Cover Sheet

Paperwork Attachment Control Number: _____

Date of service: _____

Medicaid provider number: _____

Medicaid client ID number: _____

Type of attachment: _____

Instructions:

This form is used as a cover sheet for attachments to electronic claims sent to Montana Medicaid. The *Paperwork Attachment Control Number* must be the same number as the *Attachment Control Number* on the corresponding electronic claim. This number should consist of the provider's Medicaid ID number, the client's Medicaid ID number and the date of service (mmddyyyy), each separated by a dash (9999999-999999999-99999999). This form may be copied or downloaded from our website www.mtmedicaid.org. If you have questions about which paper attachments are necessary for a claim to process, please call Provider Relations at (406) 442-1837 or (800) 624-3958.

Definitions and Acronyms

This section contains definitions, abbreviations, and acronyms used in this manual.

270/271 Transactions
The ASC X12N eligibility inquiry (270) and response (271) transactions.

276/277 Transactions
The ASC X12N claim status request (276) and response (277) transactions.

278 Transactions
The ASC X12N request for services review and response used for prior authorization.

835 Transactions
The ASC X12N payment and remittance advice (explanation of benefits) transaction.

837 Transactions
The ASC X12N professional, institutional, and dental claim transactions (each with its own separate Implementation Guide).

Accredited Standards Committee X12, Insurance Subcommittee (ASC X12N)
The ANSI-accredited standards development organization, and one of the six Designated Standards Maintenance Organizations (DSMO), that has created and is tasked to maintain the administrative and financial transactions standards adopted under HIPAA for all health plans, clearinghouses, and providers who use electronic transactions.

Administrative Rules of Montana (ARM)
The rules published by the executive departments and agencies of the state government.

Allowed Amount
The maximum amount reimbursed to a provider for a health care service as determined by Medicaid or another payer. Other cost factors, (such as cost sharing, TPL, or incurment) are often deducted from the allowed amount before final payment. Medicaid's allowed amount for each covered service is listed on the Department fee schedule.

Assignment of Benefits
A voluntary decision by the client to have insurance benefits paid directly to the provider rather than to the client. The act requires the signing of a form for the purpose. The provider is not obligated to accept an assignment of benefits. However, the provider may require assignment in order to protect the provider's revenue.

Authorization
An official approval for action taken for, or on behalf of, a Medicaid client. This approval is only valid if the client is eligible on the date of service.

Basic Medicaid
Patients with Basic Medicaid have limited Medicaid services. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Centers for Medicare and Medicaid Services (CMS)
Administers the Medicare program and oversees the state Medicaid programs. Formerly the Health Care Financing Administration (HCFA).

Children's Health Insurance Plan (CHIP)
This plan covers some children whose family incomes make them ineligible for Medicaid. DPHHS sponsors the program, which is administered by BlueCross BlueShield of Montana.

Clean Claim
A claim that can be processed without additional information from or action by the provider of the service.

Client
An individual enrolled in a Department medical assistance program.

Code of Federal Regulations (CFR)
Rules published by executive departments and agencies of the federal government.

Coinsurance
The client's financial responsibility for a medical bill as assigned by Medicaid or Medicare (usually a percentage). Medicare coinsurance is usually 20% of the Medicare allowed amount.

Conversion Factor
A state specific dollar amount that converts relative values into an actual fee. This calculation allows each payer to adopt the RBRVS to its own economy.

Copayment
The client's financial responsibility for a medical bill as assigned by Medicaid (usually a flat fee).

Cosmetic
Serving to modify or improve the appearance of a physical feature, defect, or irregularity.

Cost Sharing
The client's financial responsibility for a medical bill, usually in the form of a copayment (flat fee) or coinsurance (percentage of charges).

Crossovers
Claims for clients who have both Medicare and Medicaid. These claims may come electronically from Medicare or directly from the provider.

DPHHS, State Agency
The Montana Department of Public Health and Human Services (DPHHS or Department) is the designated State Agency that administers the Medicaid program. The Department's legal authority is contained in Title 53, Chapter 6 MCA. At the Federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

Dual Eligibles
Clients who are covered by Medicare and Medicaid are often referred to as "dual eligibles."

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
This program provides Medicaid-covered children with comprehensive health screenings, diagnostic services, and treatment of health problems.

Emergency Services
Those services which are required to evaluate and stabilize a medical condition manifesting itself by acute symptoms of sufficient severity (including pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to

result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part.

Experimental
A non-covered item or service that researchers are studying to investigate how it affects health.

Fiscal Agent
ACS State Healthcare LLC is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 et seq.

Full Medicaid
Patients with Full Medicaid have a full scope of Medicaid benefits. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Gross Adjustment
A lump sum debit or credit that is not claim specific made to a provider.

Indian Health Service (IHS)
IHS provides health services to American Indians and Alaska Natives.

Individual Adjustment
A request for a correction to a specific paid claim.

Investigational
A non-covered item or service that researchers are studying to investigate how it affects health.

Kiosk
A "room" or area in the Montana Virtual Human Services Pavilion (VHSP) web site that contains information on the topic specified.

Mass Adjustment
Request for a correction to a group of claims meeting specific defined criteria.

Medicaid
A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad federal guidelines.

Medicaid Eligibility and Payment System (MEPS)
A computer system by which providers may access a client's eligibility, demographic, and claim status history information via the internet.

Medically Necessary
A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this definition, "course of treatment" may include mere observation or, when appropriate, no treatment at all.

Medicare
The federal health insurance program for certain aged or disabled clients.

Mental Health Services Plan (MHSP)
This plan is for individuals who have a serious emotional disturbance (SED) or a severe and disabling mental illness (SDMI), are ineligible for Medicaid, and have a family income that does not exceed an amount established by the Department.

Mentally Incompetent
According to CFR 441.251, a mentally incompetent individual means an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

Mutually Exclusive Code Pairs
These codes represent services or procedures that, based on either the CPT-4 definition or standard medical practice, would not or could not reasonably be performed at the same session by the same provider on the same patient. Codes representing these services or procedures cannot be billed together.

PASSPORT To Health
A Medicaid managed care program where the client selects a primary care provider who manages the client's health care needs.

Prior Authorization (PA)
The approval process required before certain services or supplies are paid by Medicaid. Prior authorization must be obtained before providing the service or supply.

Private-pay
When a client chooses to pay for medical services out of his or her own pocket.

Provider or Provider of Service
An institution, agency, or person:

- Having a signed agreement with the Department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the Department.

Qualified Medicare Beneficiary (QMB)
QMB clients are clients for whom Medicaid pays their Medicare premiums and some or all of their Medicare coinsurance and deductibles.

Relative Value Scale (RVS)
A numerical scale designed to permit comparisons of appropriate prices for various services. The RVS is made up of the relative value units (RVUs) for all the objects in the class for which it is developed.

Relative Value Unit
The numerical value given to each service in a relative value scale.

Remittance Advice (RA)
The results of claims processing (including paid, denied, and pending claims) are listed on the RA.

Resource-Based Relative Value Scale (RBRVS)
A method of determining physicians' fees based on the time, training, skill, and other factors required to deliver various services.

Restricted Card
When utilization of services is excessive, inappropriate, or fraudulent, a client is restricted to designated providers.

Retroactive Eligibility
When a client is determined to be eligible for Medicaid effective prior to the current date.

Sanction
The penalty for noncompliance with laws, rules, and policies regarding Medicaid. A sanction may include withholding payment from a provider or terminating Medicaid enrollment.

Special Health Services (SHS)
SHS assists children with special health care needs who are not eligible for Medicaid by paying medical costs, finding resources, and conducting clinics.

Specified Low-Income Medicare Beneficiaries (SLMB)
For these clients, Medicaid pays the Medicare premium only. They are not eligible for other Medicaid benefits, and must pay their own Medicare coinsurance and deductibles.

Spending Down
Clients with high medical expenses relative to their income can become eligible for Medicaid by "spending down" their income to specified levels. The client is responsible to pay for services received before eligibility begins, and Medicaid pays for remaining covered services.

Third Party Liability (TPL)
Any entity that is, or may be, liable to pay all or part of the medical cost of care for a Medicaid, MHSP or CHIP client.

Timely Filing
Providers must submit clean claims (claims that can be processed without additional information or documentation from or action by the provider) to Medicaid within the latest of

- 12 months from whichever is later:
  - the date of service
  - the date retroactive eligibility or disability is determined
- 6 months from the date on the Medicare explanation of benefits approving the service
- 6 months from the date on an adjustment notice from a third party payor who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Usual and Customary
The fee that the provider most frequently charges the general public for a service or item.

Virtual Human Services Pavilion (VHSP)
This internet site contains a wealth of information about Human Services, Justice, Commerce, Labor & Industry, Education, voter registration, the Governor's Office, and Montana. http://vhsp.dphhs.state.mt.us

WINASAP 2003
WINASAP 2003 is a Windows-based electronic claims entry application for Montana Medicaid. This software was developed as an alternative to submitting claims on paper. For more information contact ACE EDI Gateway (see *Key Contacts*).

Index

A

Absent parent 4.4
Acronyms C.1
Administrative Rules of Montana (ARM) C.1
Allowed amount C.1
Assignment of benefits 4.4, C.1
Authorization C.1

B

Basic Medicaid C.1
Basis of relative values 8.1
Bifocals 2.4
Bilateral services, billing for 5.7
Bill, Billing
- clients directly, when providers can and cannot 5.2
- errors, how to avoid 5.11, 6.2
- for Retroactively Eligible Clients 5.4
- Medicaid first, provider may request 4.4
- third party first, exceptions 4.3
- tips for Specific Services 5.7

Bundled codes 8.5
Bundled services 5.7

C

Cash option C.1
Centers for Medicare and Medicaid Services (CMS) C.1
Charge cap 8.5
Children's Health Insurance Plan (CHIP) 2.8, 3.3, C.2
Claim, Claims
- EPSDT/Family Planning Overrides 6.1
- errors, how to avoid 6.13
- forms 5.1
- inquiries 5.10
- mail to 6.1
- submitting Medicare claims to Medicaid 4.3
- tips 6.1

Clean claim C.2, 5.1
Client, definition C.2
Client cost sharing 5.3
Client has Medicare 4.1
Clients with other insurance 4.1

CMS C.1
CMS-1500 ..... 6.1
CMS-1500 agreement 6.12
Code, Coding
books 2.3
conventions 5.5
description, check long text 5.5
resources 5.6
suggestions 5.5
Coinsurance C.2
Common billing errors 5.11, 5.12, 5.13
Common claim errors 6.13
Completing a claim 6.1
Composition of relative values 8.2
Contact lenses, billing for 5.7
Contact lenses, coverage of 2.3
Conversion factor 8.2
Copayment C.2
Cosmetic C.2
Cost sharing
clients who are exempt 5.3
definition C.2
do not show when billing 5.3
how it is calculated 8.6
services that do not require 5.3
Coverage
limited Medicaid 2.1
of specific services 2.3
other insurance 4.1
CPT-4 ..... C.2
Crime Victim's Compensation 4.3
Crossover claims
45-day limit 4.3
and timely filing 5.1
definition C.2
no response from Medicaid 4.3
Custom agreement 5.2

D

Date of service is near end of month 2.7
Definitions and Acronyms C.1
Denial, non-specific by third party 4.4
DPHHS, State Agency C.2
Dual eligibles C.2

E

Early & Periodic Screening Diagnosis & Treatment (EPSDT) C.2
Electronic funds transfer (EFT) 7.9
Electronic remittance advice 7.1
Eligibility determination letter, attach to claim 5.4
Emergency services C.2
Essential for employment 2.1, 2.8
Examples of Medicare/Medicaid payment 8.7
Exemption, how to request 4.4
Existing frame, billing for 5.8
Existing frames, coverage of 2.4
Experimental C.3
Explanation of Medicare Benefits (EOMB) 4.2
Eye conditions, coverage for 2.2
Eye exam limits 2.4
Eye exams, billing for 5.7
Eye exams, coverage of 2.4
Eyeglass, Eyeglasses
- breakage 2.6
- Breakage and Loss form 2.7
- limits 2.4
- loss of 2.6
- ordering procedures 2.7
- services, billing for 5.8
- services, coverage of 2.4

F

FA-455 Eligibility determination letter 5.4
Fee calculation 8.1
Fee schedules 2.2
Fee schedules, how to use 5.6
Fiscal agent C.3
Forms A.1
Forms for billing 5.1
Frame
- outside the Medicaid contract, billing for 5.8
- repairs, billing 5.8
- services, billing for 5.8
- services, coverage of 2.4
- warranty 2.6

Full Medicaid C.3

G

Global periods 8.3
Gross adjustment C.3

H

Health Policy and Services Division Web Page ii.4
How modifiers change pricing 8.4

I

Indian Health Services (IHS) 4.3, C.3
Individual adjustment C.3
Insurance, when clients have other 4.1
Internal control number (ICN) 7.4, 7.8
Investigational C.3

K

Key web sites ii.4
Kiosk C.3

L

Lens add-ons, billing for 5.9
Lens add-ons, coverage of 2.5
Lens enhancement 2.5
Lens styles and materials, coverage of 2.6
Limits on exams and eyeglasses 2.3

M

Manual Organization 1.1
Medicaid
- definition C.3
- Eligibility and Payment System (MEPS) C.3
- payment and remittance advice 7.9
- payment, when different from fee schedule 8.1
- Rx form, how to submit 2.8

Medical coding conventions 5.5
Medically necessary, definitions C.3
Medically necessary, services must be 2.3
Medicare
- and Medicaid coverage and benefits 4.2
- client has 4.1
- definition C.3
- Part A 4.2
- Part B 4.2
- pays or denies a service 4.2
- submitting claims to Medicaid 4.3

Mental Health Services Plan (MHSP) 2.8, C.4
Mentally incompetent C.4
MEPS 7.1

Modifier, Modifiers
50 ....5.7
for assistant at surgery 5.7
for bilateral 5.7
for co-surgery 5.7
for multiple procedures 5.7
for team surgery 5.7
how they change pricing 8.4
informational 5.7
other 8.3
pricing 5.7
use for multiple visits 5.4
Montana Breast and Cervical Cancer Health Plan (MBCCH) C.4
Montana Eligibility and Payment System (MEPS) 7.1
Montana Medicaid Claim Inquiry form 5.11
Montana Medicaid Rx Form, tips for compleing 2.7
Multiple visits on same date 5.4
Mutually exclusive code pairs C.4

N

Non-covered services 2.2
Notices 1.1

O

Other insurance 4.1, 5.4
Other programs 5.13
Other sources of coverage, how to identify 4.1

P

PASSPORT to Health 3.1, C.4
Payment
by Medicaid, weekly or biweekly 7.9
by report 8.5
for eyeglasses 8.6
scenario 1 ....8.8
scenario 2 ....8.8
scenario 4 ....8.9
scenario 5 ....8.9
Payment, how calculated on Medicare crossover claims 8.7
Payment, how calculated on TPL claims 8.7
Photochromic 2.5
Place of service 5.4
Place of service codes B.1
Polycarbonate lenses 2.5
Potential liability 4.3

Prior Authorization (PA)
basics 3.1
criteria 3.2
definition C.4
Private pay C.4
Professional and technical components 8.3
Professional differentials 8.5
Progressive 2.5
Provider information web site ii.4
Provider or provider of service C.4

Q

QMB only coverage 2.1, 4.3
Qualified Medicare Beneficiary (QMB) C.4
Questions answered 1.1

R

RBRVS fee schedule 8.1
Relative value scale (RVS) C.4
Relative value unit C.4
Remittance advice (RA) C.4
Replacement lenses and frames, billing for 5.9
Replacement lenses and frames, coverage of 2.6
Replacement pages 1.1
Requesting an exemption 4.4
Resource-based relative value scale (RBRVS) C.4
Response, none from third party 4.4, 4.5
Restricted card 3.1, C.4
Retroactive eligibility 2.3, C.4
Retroactively eligible clients, billing for 5.4
Routine agreement 5.2

S

Sanction C.4
Service, Services
non-covered 2.2
paid or denied by Medicare 4.2
that do not require co-pay 5.3
when providers cannot deny 5.3
within scope of practice 2.1
Site of service differential 8.2
Slab-off and fresnell prism 2.5
Special Health Services (SHS) C.5
Specified Low-Income Medicare Beneficiaries (SLMB) C.5
Spending down C.5

Status codes 8.5
Submitting the Medicaid Rx form 2.8
Suggestions for coding 5.5

T

Third party does not respond 4.5
Third party liability (TPL), definition C.5
Third party pays or denies a claim 4.4
Timely filing 5.1, 6.1, C.5
Timely filing denials, how to avoid 5.1
Tints 2.5
TPL, when a client has 4.3
Transition adjustor 8.2

U

Uncut lenses 2.6
Usual and customary, definition C.5
Usual and customary charge 5.4
UV and scratch-resistant coatings 2.5

V

Virtual Human Services Pavilion (VHSP) ii.4, C.5

W

Web sites ii.4
WINASAP 2003 .....5.9